Welcome to Primal Plate Wellness!

To get started, it would be helpful to know the following info about you.

Name:_____ **Please call me:** _____

Email: _____ **Phone:** _____

Date of birth: _____ ❑ Male ❑ Female

Relationship status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated ❑ Engaged ❑ Long-term relationship

Occupation: _____ **Employer:** _____

How many hours do you work per week? _____

If retired, former occupation(s): _____

If you were referred, who can I thank? _____

MEDICAL HISTORY

Your height: _____ (ft.) _____ (inches) **Weight:** _____

Blood type: ❑ Type A ❑ Type b ❑ Type AB ❑ Type O ❑ Don't know

Have you ever been hospitalized? ❑ Yes ❑ No

If yes, please list the reason(s): _____

_____

Do you take laxatives? ❑ Yes ❑ No

If yes, which one(s): ❑ Metamucil ❑ Flaxseed ❑ Miralax ❑ Citrucel ❑ Senna ❑ Rhubarb root ❑ Ducolax Other: _____

How often do you take laxatives? ❑ Daily ❑ Weekly ❑ Less than twice a month

Do you currently take over-the-counter (OTC) antacids? ❑ Yes ❑ No

If yes, which one(s): ❑ Prilosec ❑ Prevacid ❑ Nexium ❑ Zantac ❑ Tagamet ❑ Tums ❑ Pepcid ❑ Maalox ❑ Mylanta ❑ Rolaids Other: _____

How often do you use OTC antacids? ❑ Daily ❑ Weekly ❑ Less than twice a month

Do you currently take OTC pain relievers (Advil, Tylenol, Aspirin, etc.)? ❑ Yes ❑ No

If yes, how often? ❑ Daily ❑ Bedtime ❑ Weekly ❑ Less than twice a month

List any prescription medications you currently take:

	Medication	Dosage	What do you take this for?
1.			
2.			
3.			
4.			
5.			
6.			

List any nutritional supplements you currently take:

	Name & Brand	Dosage	What do you take this for?
1.			
2.			
3.			
4.			
5.			
6.			

Have you been diagnosed with an autoimmune condition? ❑ Yes ❑ No

If yes, which one(s):_____

What are the symptoms you're experiencing?

❑ Fatigue ❑ Achy joints and/or muscles ❑ Recurring fever ❑ Brain fog ❑ Skin rashes

❑ Digestive issues ❑ Hair loss ❑ Anxiety ❑ Infertility ❑ Environmental allergies

❑ Weight loss ❑ Weight gain ❑ Constipation ❑ Diarrhea ❑ Heartburn/Acid reflux

❑ Food allergies/sensitivities ❑ Sleep disturbances ❑ Other:_____

Have you ever had any of the following?

❑ Mononucleosis ❑ Chickenpox ❑ Cytomegalovirus ❑ Candida ❑ Lyme disease

If you are 50-75 years old, have you received appropriate screening for colorectal cancer, such as colonoscopy, fecal blood testing or sigmoidoscopy? ❑ Yes ❑ No

If yes, results were: ❑ Normal ❑ Positive for benign polyps ❑ Positive for cancerous polyps

Please check all that apply to you

- ❑ Arthritis
- ❑ Allergies/hay fever
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Autoimmune disease
- ❑ Blood pressure problems
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chronic fatigue syndrome
- ❑ Carpal tunnel syndrome
- ❑ Cholesterol, elevated
- ❑ Circulatory problems
- ❑ Colitis
- ❑ Dental problems
- ❑ Depression
- ❑ Diabetes
- ❑ Diverticular disease
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Epilespy
- ❑ Emphysema
- ❑ Eyes, ears, nose and throat problems
- ❑ Environmental sensitivities
- ❑ Fibromyalgia
- ❑ Genetic disorders
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart disease
- ❑ Infection, chronic
- ❑ Kidney/bladder disease
- ❑ Learning disabilities
- ❑ Liver/gallbladder disease
- ❑ Mental illness
- ❑ Migraine headaches
- ❑ Neurological problems
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Sinus problems
- ❑ Skin problems/eczema
- ❑ Stroke
- ❑ Thyroid issues
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Urinary tract infections
- ❑ Vericose veins
- ❑ Gastroesophageal reflux disease
- ❑ Inflammatory bowel syndrome
- ❑ Irritable bowel syndrome

Family Health History (Parents & Siblings)

- ❑ Arthritis
- ❑ Asthema
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Cancer
- ❑ Diabetes
- ❑ Digestive disorders
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Genetic disorder
- ❑ Heart disease
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological disorders
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Stroke
- ❑ Suicide
- ❑ Other

_____

_____

_____

WOMEN'S HEALTH

Check if you have had any of these conditions:

❑ PMS ❑ Endometriosis ❑ Infertility ❑ Yeast infections ❑ STD ❑ Fibrocystic breasts ❑ D&C

❑ Loss of libido ❑ Pain between cycles ❑ Ovarian cysts ❑ Irregular periods ❑ Menopause

❑ Surgical menopause ❑ Hot flashes ❑ Breast cancer ❑ Painful intercourse ❑ Cervical dysplasia

MEN'S HEALTH

Please check all that pertain:

❑ Frequent urination ❑ Difficulty urinating ❑ Infertility ❑ STD ❑ Loss of libido

❑ Difficulty with erection ❑ Prostate enlargement ❑ Prostate cancer

BOWEL HABITS

How frequently do you have a bowel movement? ❑ 2-3 times/day ❑ once a day
❑ Every other day ❑ Less than three times/week

Consistency: ❑ Smooth/soft ❑ Hard/lumpy ❑ Loose/soft ❑ Watery ❑ Separate, hard lumps

HEALTH HABITS & LIFESTYLE

Do you use tobacco products? ❑ Yes ❑ No Cigarettes/day _____ Cigars/day _____

Are you exposed to 2nd hand smoke? ❑ Yes ❑ No

Are you exposed to toxic substances at work? ❑ Yes ❑ No

At home? ❑ Yes ❑ No

If yes, please describe: _____

Wine ❑ Yes ❑ No Glasses / day or week _____

Liquor ❑ Yes ❑ No Ounces / day or week _____

Beer ❑ Yes ❑ No Glasses / day or week _____

Marijuana ❑ Yes ❑ No Times / week or month_____

Do you have a regular bedtime? ❑ Yes ❑ No

How many hours do you sleep? _____ Do you wake up during the night? ❑ Yes ❑ No

If yes, do you find it difficult to go back to sleep? ❑ Yes ❑ No ❑ Sometimes

Do you do aerobic exercise? ❑ Yes ❑ No Times/Wk _____ Min/Session _____

Do you do strengthening exercise? ❑ Yes ❑ No Times/Wk _____ Min/Session _____

Rate your stress level? ❑ Extreme ❑ High ❑ Manageable ❑ Low

Do you engage in any stress reducing activities? ❑ Yoga ❑ Tai Chi ❑ Meditation
❑ Deep breathing ❑ Volunteer work Other: _____

Have you or your family recently experienced any major life changes? _____

_____

What brings you joy? (Include even if not currently engaged in the particular activity):

_____

_____

NUTRITIONAL HISTORY & HABITS

Are you currently following a particular dietary style?

❑ Paleo ❑ Keto ❑ Mediterranean / Anti-inflammatory ❑ Auto Immune Protocol (AIP)

❑ Vegetarian ❑ Vegan ❑ Low FODMAP ❑ Whole 30 ❑ Kosher ❑ Gluten-free

❑ Dairy-free ❑ Other: _____

Do you have any food allergies, sensitivities or restrictions? _____

_____

Do you crave any of the following?

❑ Sugar ❑ Meat ❑ Salt ❑ Chocolate ❑ Bread ❑ Fried foods

❑ Desserts ❑ Fat ❑ Caffeine ❑ Alcohol Other _____

When do cravings occur (a.m. / p.m. / between meals, etc.) _____

_____

Do you drink soda? ❑ Yes ❑ No If yes, diet or regular? _____

How often? ❑ Daily ❑ Weekly ❑ Less than twice a month

Does your current diet differ from your diet in the past? ❑ Yes ❑ No

If yes, please describe: _____

At which stores do you normally grocery shop? _____

Which of the following do you purchase on a regular basis: Check all that apply.

❑ Conventional produce ❑ Organic produce ❑ Conventional beef ❑ Grass-fed beef

❑ Conventional poultry ❑ Free-range poultry ❑ Farmed fish ❑ Wild caught fish

❑ Conventional eggs ❑ Organic, pastured / free range eggs

❑ Conventional non-perishables (canned/prepared foods) ❑ Organic / non GMO non-perishables

When preparing meals at home, are you: ❑ Planner ❑ Spontaneous ❑ Depends

Do you like to cook? ❑ Yes! ❑ When I have time ❑ Indifferent ❑ No

Who does the majority of meal planning and preparation in your home? ❑ Me ❑ Partner

How often do you eat breakfast? ❑ Everyday ❑ Sometimes ❑ Weekends only

When you were a child, did your family often eat meals together? ❑ Yes ❑ No

Which describes the majority of your meal times? (Check all that apply):

❑ At the table with family/friends ❑ Working ❑ Surfing the web ❑ Watching TV

❑ In the car ❑ Alone Other _____

How often do you eat out? Indicate # of times either per week or per month.

Breakfast _____ times per week / month

Lunch _____ times per week / month

Dinner _____ times per week / month

List three areas where you have specific concerns or would like to make changes.

1. _____

2. _____

3. _____

Have you tried to make any of these changes in the past? ❑ Yes ❑ No

If yes, what was your experience with these efforts? _____

_____

_____

On a scale of 1 to 10 (1 is low, 10 is high), how would you rate your willingness to consider making any changes to your diet and/or fitness level at this point in your life?

1 2 3 4 5 6 7 8 9 10

Would you like to subscribe to the Primal Plate Wellness blog? ❑ Yes ❑ No